SEXUALLY TRANSMITTED DISEASE - CONFIDENTIAL MORBIDITY REPORT

Date of Report: ___ - ___ - ___ ☐ New

Date of Report: ___ - ___ - ___ ☐ Update

Medical record attached

Report Done by:

Diagnosing Medical Practitioner Information (Write legibly or use clinic stamp. For a custom form with your information, email stdreporting@ph.lacounty.gov)

Provider Name:
Dept./Clinic:
Facility Name:
Address:
City/State/Zip Code:
Telephone Number: Fax Number:

PATIENT'S LAST NAME | FIRST NAME | M.I.

MEDICAL RECORD NUMBER | BIRTHDATE ___ - ___ - ___ | AGE

PATIENT'S STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

HOME TEL. ___ - ___ - ___ | WORK TEL. ___ - ___ - ___ | UNSTABLE HOUSING/UNHOUSED

CELL ___ - ___ - ___ | E-MAIL ADDRESS

Patient Pregnant? ☐Unk. ☐No ☐Yes ➤**LMP (mm/dd/yy)**:

Partner Pregnant? ☐Unk. ☐No ☐Yes

Gender:
☐Male
☐Female
☐Transgender MtoF
☐Transgender FtoM
☐Unknown
☐Other

Marital Status:
☐Single
☐Married/ Domestic Partnership
☐Separated
☐Divorced
☐Widowed
Living with Partner

Race(s):
☐White
☐Black/African American
☐Native American/Alaska Native
☐Asian/Asian American
☐Native Hawaiian/ Pacific Islander
☐Unknown
Other:_______________

Ethnicity:
☐Hispanic/Latino/a
☐Non-Hispanic/ Non-Latino/a

Primary Language:
☐English
☐Spanish
☐Other:____________

Gender of Sex Partner(s):
☐Male
☐Female
☐Transgender MtoF
☐Transgender FtoM
☐Other
☐Unknown
☐Refused

Disease(s) Being Reported: **Chancroid** **Gonorrhea** ☐**Syphilis** (for syphilis fill out back of form & fax both sides)

Site/specimen(s) with positive result:

Gonorrhea
☐Urine
☐Cervix
☐Vagina
☐Urethra
☐Rectum
☐Pharyngeal
☐Other:____________

Specimen collection date (mm/dd/yy):

Treatment date (mm/dd/yy):

Allergic to: ☐Penicillin ☐ Cephalosporins

Medication(s) and Doses: ☐Not treated
☐Ceftriaxone 500mg
☐Ceftriaxone 1g IM
☐Azithromycin 2g po
☐Cefixime 800mg po
☐Gentamicin 240 mg IM
Doxycycline 100mg po
DoxyPEP (Doxycycline 200mg po)
Other med(s): ____

____

Gonorrhea Diagnosis
☐ Asymptomatic
☐ Symptomatic - uncomplicated Eye infection
☐ Disseminated gonorrhea (DGI)
☐ Other:______________

Partner Info.: Number Partners (last 60 days): | Number Treated (not including PDPT): | Number Given PDPT (Patient Delivered Partner Therapy):

Revised: 01/15/2025

PATIENT'S LAST NAME | FIRST NAME | M.I.

PATIENT'S DATE OF BIRTH __ - __ - ____

PROVIDER NAME ______ PROVIDER TEL # ______ PROVIDER FAX # ______

Syphilis

Syphilis stage

☐ Primary (lesion/sore present)
☐ Secondary (rash/condyloma lata present)
Early latent (≤1 year)
Late latent (>1 year)
Probable Congenital syphilis
Neurosyphilis (if checked, indicate stage above)

Symptoms/Signs

☐ None ☐ Genital ulcer ☐ Rectal/perianal ulcer ☐ Oral ulcer
☐ Rash ☐ Palmar/Plantar ☐ Condyloma lata Otic
☐ Neurological symptoms ☐ Ocular
Other: ______

Onset Date (mm/dd/yy):

Laboratory Name: ______

Blood test - collection date (mm/dd/yy):

RPR ☐ Neg ☐ Pos: } Titer 1: ____
VDRL ☐ Neg ☐ Pos: }
FTA-ABS ☐ Neg ☐ Pos
TP-PA ☐ Neg ☐ Pos
EIA/CIA ☐ Neg ☐ Pos
Other (test name/result): ______

CSF – collection date (mm/dd/yy):

CSF-VDRL ☐ Neg ☐ Pos: Titer 1: ____

CSF WBC ___ mm3 CSF protein ___ mg/dl

Infants only ☐ Live birth ☐ Still birth Neonatal death (Death <29 days after birth)

Gestation __ weeks Weight ____ grams

Long bone x-rays consistent with congenital syphilis? ☐ No ☐ Yes ☐ Unknown ☐ Not done

Infant's serum RPR titer 4X mothers? ☐ No ☐ Yes

Mothers only (complete only if this is baby's CMR)
Syphilis stage: Neurosyphilis
Serology (at delivery) ☐ RPR ☐ VDRL Titer 1: ___
Rx (meds & date/s): ______

Partner Information
Number Partners (last 12 months): ___ Number Treated: ___

Patient Rx - Medication(s) and Doses: **Treatment date(mm/dd/yy):** **Allergic to**: ☐ Penicillin ☐ Cephalosporins ☐ Not treated

☐ Bicillin LA or Extencilline 2.4MU IM once
☐ Bicillin LA or Extencilline 2.4MU IM once
☐ Bicillin LA or Extencilline 2.4MU IM once
Doxycycline 100mg bid x 14 d
☐ Doxycycline 100mg bid x 28 d

Treatment date(mm/dd/yy):

Ceftriaxone 1 g IM or IV x10-14 d
DoxyPEP (Doxycycline 200mg po)

Treatment start date(mm/dd/yy): **Treatment end date(mm/dd/yy):**

Aqueous crystalline penicillin G 18-24MU IV

Other meds: ______ **Treatment date(mm/dd/yy):**

CONGENITAL SYPHILIS

Provide info. below on MOTHER(if this is infant's CMR) **or INFANT** (if this is mother's CMR).
Send CMRs for both mother & infant

LAST NAME | FIRST NAME | M.I.

MEDICAL RECORD NUMBER | BIRTHDATE __ - __ - ____

FAX TO: (213) 749-9602 OR
MAIL TO:
Division of HIV and STD Programs
600 S. Commonwealth Ave., 10th Floor,
Los Angeles, CA 90005

Complete STD CMR on-line or download at:
http://publichealth.lacounty.gov/dhsp/InfoForProviders.htm
For a custom electronic or printed form, prepopulated with your information, contact: stdreporting@ph.lacounty.gov or (213) 741-8000. Do not send completed forms by email.
For info. on STD reporting: http://publichealth.lacounty.gov/dhsp/ReportCase.htm (213) 368-7441
For info. on HIV reporting: http://publichealth.lacounty.gov/dhsp/ReportCase.htm (213) 351-8516